UNIVERSITY OF TORONTO
MEDICAL JOURNAL

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APRIL 1957

VOLUME XXXIV NUMBER 6

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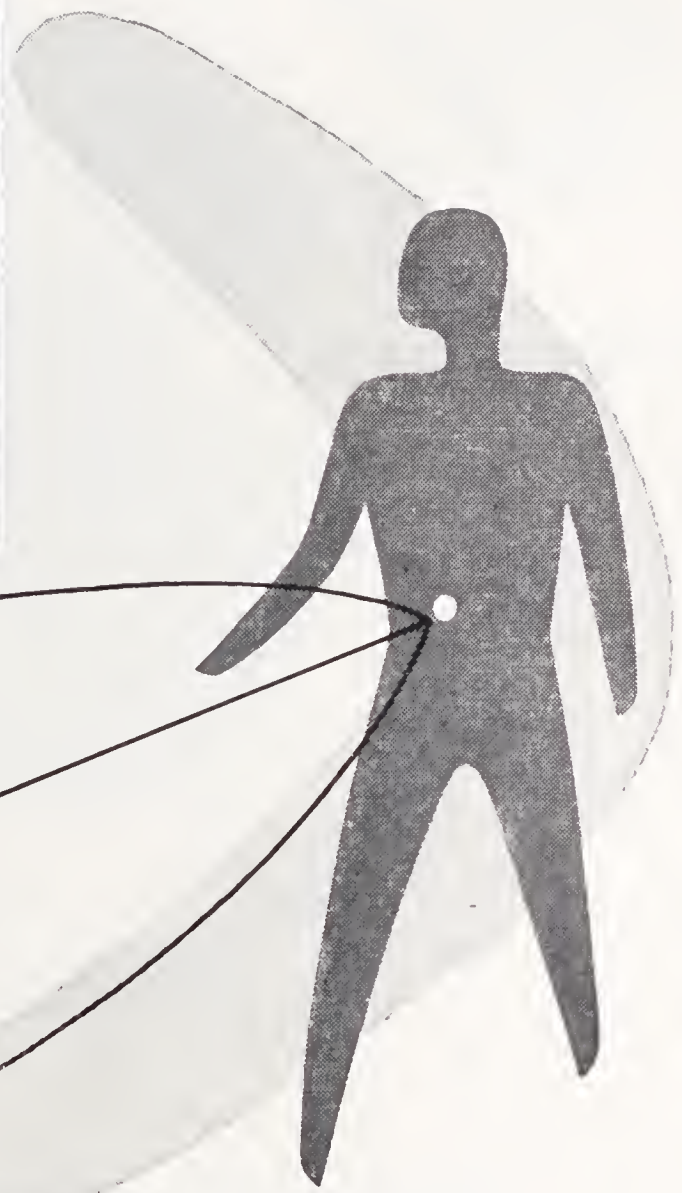

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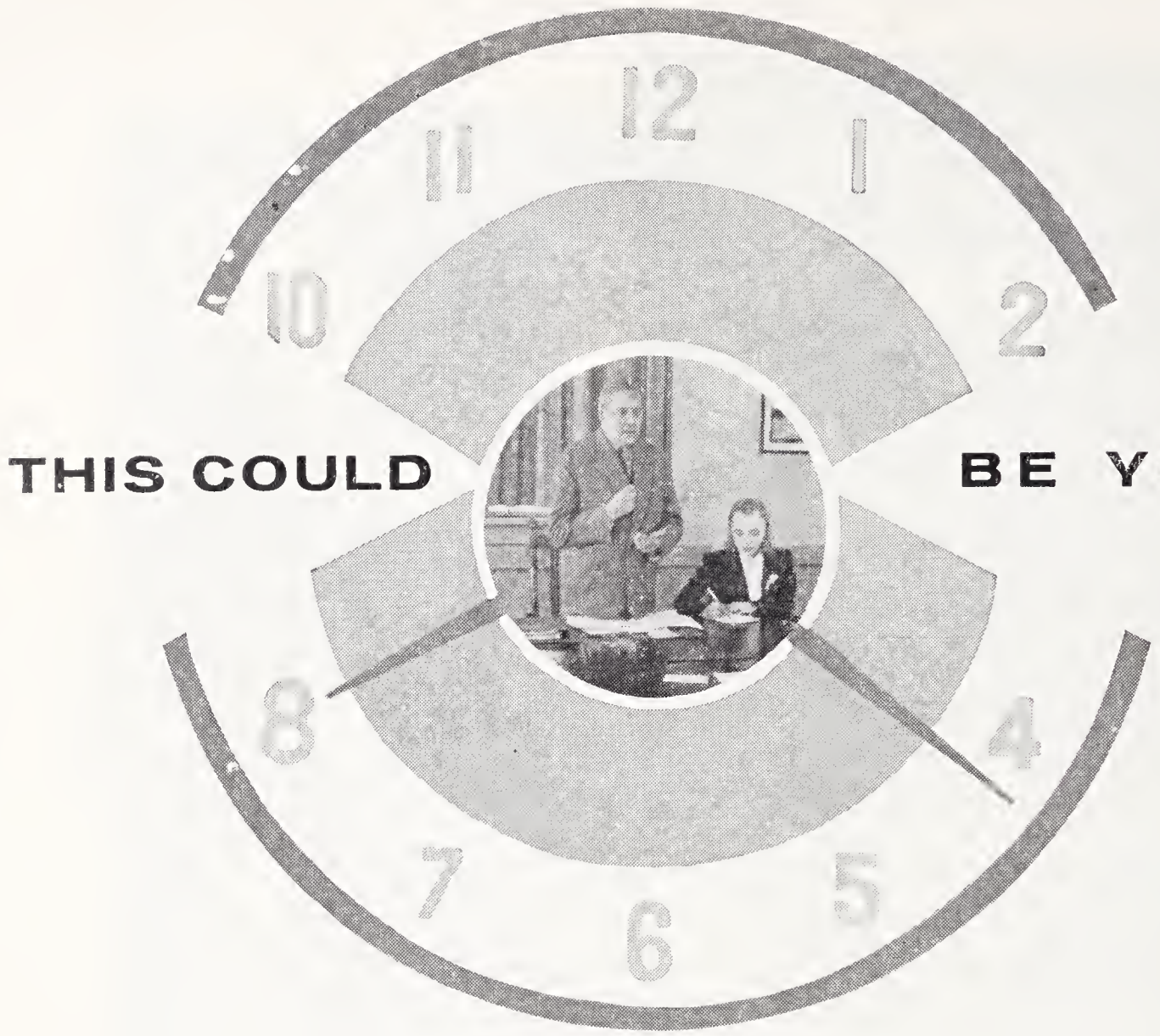

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THE ONTARIO RETAIL PHARMACISTS' ASSOCIATION

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EDITORIALS

Resume — Thirty-Three Years of Editorials

This, the last issue of this year, completes our thirty-third year of publication. When the Journal was started in the autumn of 1923, it was a new project, the first student Medical Journal in Canada, and a very ambitious undertaking. Seven issues were published during the school year and sold to the students for 20 cents each or $1.25 per volume. It was not until 1935 that it was made a subsidized function of the Medical Society and provided to all students free. The first year was apparently successful for it was continued in subsequent years, though there was some editorial doubt of its ultimate success at times. As usual the troubles were largely financial.

It is interesting to note that the first year of publication was probably the best for several years. In 1924, the editor comments that extra copies of volume I are available, and bound volumes are obtainable from the press. By 1927, all extra copies were gone, and in February 1929, the editors were offering to buy at 40 cents per copy any or all issues of volume I, to satisfy the demand. Consideration was given at that time to reprinting the entire volume. It is probable that all our copies were removed at this time, for at present there is not a single copy in our files.

Their main aim was the publishing of student articles of general interest, and some excellent writing was done. The modern student who fancies that, with antibiotics and the Salk vaccine, Medicine has just in the last ten years moved out of the dark ages would be well advised to read some of the articles presented in 1928. They then believed the same thing, and with equal justification. Insulin, antitoxins of many new types, and modern concepts of pathology and body chemistry were just as revolutionary in that era. In the February 1926 issue, appears a comment on recent work on Bacteriophage by d'Herelle, (a noted researcher of the time but more important, a Canadian). The article is very conservative in its wording, but one can almost sense the feeling some may have had that perhaps here lay the answer to bacterial infection. In the paper, the virus nature of bacteriophage was under hot discussion, d'Herelle supporting it, and others proposing numerous other theories of its nature. These included catalytic or enzyme-like agents, nutritional disease of the bacteria which is hereditary and contagious, or some chemical or physical imbalance or substance arising within bacteria themselves. Every age has its promise of great discovery.

By reading the editorials and non-technical contributions over the years, a very good idea of the temper of the times and the personality of the writer can be gained. The history of the Journal could be divided into epochs by the nature of the subjects discussed and the approach taken. The first seven or eight years are

marked by an unusual vigor. The interne, the student and the graduate are all eonsidered seriously with respeet to the profession and soeiety. This was a period when all these things were important. Many student gripes are aired which sound familiar today. The responsibility of the interne and the hospital, the pay, the duties of interneship are all diseussed in several artieles before 1930, but are not touehed again until 1944 or 1945. These problems are similar today.

The period from 1930 to 1935 refleets the depression. People are more restrained and eautious. The subjects dealt with are mueh more loeal and of less sweeping intent. Mueh space is spent on the problem of the writing of good artieles, the essenee of a good physieian, why it is neeessary to study hard, and similar topics. It is not till aroumd 1936 or 1937 that we see a reawakening of interest in broader topics perhaps beeause the depression is becoming less severe, things seem to be improving. In the War years, the editorials are more sombre and deal with aceepted topics in a basieally conservative style. During a national emergeney one is not too inclined to start minor crusades on small or local topics or hurl semanties at the ears of those who are being pressed through school so that they can join the army.

Sinee the war, the policy has been varied. For several years there was an awakening of missionary zeal, and all the various topics were trotted out for re-examination. But this has later been interspersed with periods when editorials avoided eontroversial subjeets or were only written oecasionally. Certainly we have not seen the vigor whieh was displayed in the twenties. Perhaps now we have eome to accept too many things without serious question and hence are not interested when others ask questions. Or maybe it is just that all the things that need to be said have been said. But no Editor worth his salt would ever admit that. He would be left with nothing to say.

There has always been the attempt to attract interest by new features. Abstraets were first added in 1933 and have been included frequently since. A "Letters to the Editor" column on a limited scale seemed to flourish for a few years in about 1929 and 1930, but no editor seemed to approve of it, and it was gradually dropped.

One frequently sees editorial comment about internesships throughout the pages of the Journal. One of the early ones in the February 1928 issue, was entitled "Should Hospital Internes be paid". It takes issue with the large teaching hospitals who announce with pride that they do not pay their house staff. There is a distinet parallel to the attempts by the Staff Student Relations Committee this year to have their plea recognized by the Teaching Hospitals here.

In February 1929, a report from the C.M.A.J. is eommented on and figures quoted to show that in spite of the fact that facilities in Canada were never better, for the seven years 1922 to 1928, 37 per eent of the graduating students in Canada interned in the United States. In 1924, the figure was 42 per cent. These figures are even higher than today. Other later eomments on amount of pay, faeilities for internes and finally compulsory internesships are dealt with in turn, and eaeh of these has a familiar ring.

As an editor, one finds it progressively harder to say things that need saying whieh have not been said too many times before. Hence all too many are

innocuous little comments which fill the editorial page but nothing more. It is probably not too surprising that not many people read them. One editor in 1927 whimsically concludes his editorial about the lack of interest and contributions from the junior years by observing that this apathy has the advantage of providing the editor with something to write about each year.

The Journal has had its good years and its bad years, its inspired, imaginative years and its pedantic ones. We hope that this year's Journal will uphold the standard even though we failed in two of the three things we set out to do. These were, to get the Journals out on time, and provide articles of wide interest for all years. We were fairly successful in getting all student articles this year, while still maintaining a good standard of writing. Next year, the new staff has several ideas to provide interest and variety which we were not able to implement this year. These take the form of new departments and new sections to add variety. Those of us who are leaving this year wish them good luck and success.

In This Issue

We have received a letter from Dr. B. A. Clark, a recent graduate of this university, who describes her experience in setting up General practice on a short term basis, prior to entering further postgraduate work. It is presented here since we feel that some may be interested in some of the details, and in the fact that it can be done profitably for a short period.

The two articles on Alcohol Addiction by J. M. Harvey and J. A. L. Gordon, and the article on Vasospastic Diseases by V. N. Kyle, are from papers originally presented before the A.O.A. Honour Medical Society.

THE SHORT-TERM PRACTICE

B. A. CLARK, M.D.

WHEN the question of post-graduate study comes up, a lot of us hesitate because we are so far in the hole. But in a year in general practice you can go farther than you think toward getting on your feet financially.

You can be assistant to an established practitioner, when you will receive $150 to $250 a week. Car allowance and hours are an individual matter. The agreement should be in writing regardless of how friendly the principals are, and the best arrangement you can make is to work on a fee-for-service basis. You will feel more incentive this way, still have an experienced person nearby, and make more money.

It is the opinion of a dozen Toronto graduates who have tried it, that working for someone else always brings difficulties, and being on your own with your own practice is much more satisfying. But, you say, you only wish to practise for a few months. That's fine. Here's what it cost me to set up practice in 1956, in a northern Ontario town:

Desk, birch, on sale	26.00
Examining lamp, gooseneck	12.00
Examining cot (rollaway)	15.00
Bathroom scale	8.00
New phone installed, 1st month rental	7.00
Unpainted chest of drawers	18.00
Syringes, tape, gauze, test tubes, misc. drugs	24.00
Stationery, stamps	10.00
	120.00

I received permission to use a hospital, rented an office for $40 a month, shared the waiting room, borrowed three small chairs, and a patient presented me with a small sterilizer. From medical school I already had examining instruments and microscope.

For the first month there was lots of time to be my own nurse, and after that I had help, with office hours 2-4:30 and 7-9. Income while getting started can be supplemented by public health work. They often need extra doctors to give injections in the schools, and the polio foundation pays $10 an hour. Local doctors are often glad of someone to take over while they have a holiday, and if you have the opportunity to assist at operations, the fees are very welcome in the beginning.

I had the advantage of being the only woman doctor in the community and from the obstetrics and gynecology which came my way, often whole families came to me. I made a point of having the children enjoy coming: toys in the waiting room, as few needles as possible, and an occasional sucker. I read a ton of literature on listening-to-the-patient's-problem, and listened. The pace was killing: the hours were irregular and long, but the work was exciting and vital. Life was never boring! Everything happened from a cavernous sinus thrombosis with lung abscess to several fractures, three stove-in chests and twins (both breeches). Every day was fascinating! General practice is wonderful!

On a short term basis it is perfectly feasible. You must leave your patients in capable hands when your time is up. In the first fifteen weeks on my own, gross income was $6070, expenses $1987, net income $4084, with $650 still to be collected. Many people have done better. And the experience is invaluable.

ON PSYCHOTHERAPY—AIMS AND METHODS

D. CAPPON, M.B.

Last of a series of three articles on Psychotherapy

MY remarks from here on will be concerned with non-directive, integrative, mostly long term, mostly individual psychotherapy.

THE AIMS ARE

1. Understanding the structure of the patient's personality in its social setting; understanding how the patient functions as a whole being, and how, out of the context of his life experience and motivations he came to fall ill.

2. Sharing that understanding with the patient so that he will see and experience himself in greater depth and extent, so that he will alter his self-picture and his perception of his world, past and present; so that he will choose to reaet differently to his environment and to himself. Thus, hoping that he will choose to discard those ego defences, those faulty reaction patterns, (maladaptations) of behaviour, feeling, ideation and secondary perceptions which form his constellation of symptoms, physical and mental; and that he will substitute for these faulty reactions others which are less painful and injurious to him or to his world, and so healthier. That is, hoping he will allow the syndrome which formed his neurosis to become, at least in part dissolved and replaeed, so that his whole being will function better.

3. So synthesizing the new knowledge and experience gained as to eleet to change aspeets of his personality which eontain his eomplex, the substratum for his neurosis. And in so far as this is possible, freeing mental energy (libido) for ever wider, more satisfying and rewarding investments. And in so far as this is possible, pari-passu experiencing the taste and ingesting a few mouthfuls of the all too-precious honeyed crumbs of happiness.

The surplus bonus to these ideal aims, over and above the relief of pain and correction of incapacity is when the patient says, as he sometimes does in those rare moments of delight to a psychotherapist who knows that shortly he will be avoided like plague by the patient restored to health, "I'm glad I got sick and have had to come to be treated by you; else I might have at best merely half lived, and now I'm whole and wholesome and happy as I've never been before."

As you see the cornerstone of the foundation of psychotherapy is self-perception. When you remember that Socrates said, "And still I am not able to know myself as the Delphic oracle bids me do"; when you remember the mortal struggle of St. Augustine, probably the first to investigate man's inner life; when you remember Petrarch abandoning his life of plenty and the highest peak of the Alps at Avignon, in search of his soul; the Cartesian school of philosophers, "Cogito ergo sum" (I think therefore I am); Jean Jacques Rousseau's confessions; Goethe and countless others to Freud and Jung and since; when you

have tried exercises in self-perception for yourselves, you will know what a hard stone this is to lay. But when the stones are laid, and one directs the beam of consciousness within, what horrors and wonders to behold! Then as Lao Tse said, "One may know the world without stepping beyond one's threshold, one may perceive the wonder of heaven, without looking through the window". For the self is a veritable microcosm. Even if one were to deny that if it were not for our consciousness there would be no existence, and if it were not for our thus enlarged consciousness there would be little reality, one must accept that we cannot know that the world is not an irrational mirage, a chaotic cosmos despite the nice laws we ascribe to it, save through our faith and through our knowledge of what is ordered and integrated within ourselves.

In descent from these Olympian lyrics we find disappointment. Even if you know yourself, one cannot guarantee that "to your own self be true". Worse, the disappointment of all kinds of analytical psychotherapy has been that even an emotional revolution in self-concept does not ensure that the individual will feel or even act other than the way he used to do. Hence the sad failures in psychotherapy. Unfortunately, unlike the surgeon and the physician, the psychiatrist cannot act independently from what, for want of a better term one may call the patient's ultimate will. The hope remains always that once a person has seen the light he will do right — but it does not necessarily follow that he will, nor even that he can. But I must most emphatically draw your attention here to the unfairness of equating statistically the failures in this sort of therapeutic process with the failures in all or in any others. Here one may say that the patient had the greatest choice to become well or remain ill, limited though this choice is. Whereas in any process short of the one described no such thing may be claimed. Thus qualitatively "insight giving therapy" differs from all other. It is the hardest and the only one likely to achieve permanent success.

Let us have a final fling at lyrics and so at what is one's highest hope of normalcy in man. That he should individuate (realize all his inner and unique potentials and relate himself to his own self comfortably and with integrity) and socialize (that he should relate to society in a state of feeling of belongingness). That in doing so he strikes a working balance with a range of physical and social environments, maintaining the balance despite constant changes. That he relates meaningfully and responsively to others, advancing their welfare and also the principles and values which enjoy his loyalty. That he be tolerant to uncertainty and make constructive efforts in the absence of immediate rewards and final answers. That he strain for further understanding both of himself and the outside world in the belief that thus he may influence his destiny and he has the courage to attempt this. Last but not least that he creates as he lives.

As he may do this his personality congeals about a golden mean thus: he be

1. polite but not weak
2. modest but not servile
3. sociable but not an exhibitionist
4. independent but not isolated
5. adventurous, brave and positive, but neither rash nor violently aggressive
6. sensitive but not touchy
7. careful but not timid
8. generous and benevolent but not sacrificial nor totally self-abnegating.
9. enthusiastic, yet not prejudiced
10. peaceful yet not negative
11. gentle but not soft
12. happy and joyful, but not superficial nor licentious
13. self-controlled, self-disciplined,

self-organized and neat but not fastidious, finicky or self-torturing.

14. self understanding and self-respecting but not conceited

15. tolerant without being a self-appointed martyr.

16. patriotic but not narrow-minded

17. religious but not fanatic

18. free but not chaotic – give without losing – take without grabbing, do his duty without forgetting his rights and insist on his rights without neglecting his duty.

19. He should have an active, creative intellect, clever constructive hands, and expressive tongue and a loving heart.

20. Last but not least, he should be loyal to the family as well as the community; and since this is found to be possible, loyal to the community and also to the State; and since this is found to be possible, loyal to the State, and yet cognizant of the world community; and in so far as this is possible, he would be at peace with his God, and warm and kindly to the God others worship.

Criteria of Recovery

A discussion of prognosis and hence the natural history of psychiatric disorders, of indications for treatment, rating recovery and estimating residual disability will be offered in a subsequent lecture on "Results of Psychotherapy". Suffice it to state here that the indices of recovery are:

1. Subjective – Intrapersonal

(a) the disappearance of the subjective symptoms which were initially recorded as the reason for a patient presenting himself for treatment.

(b) an improved state of well-being.

These are reported by the patient:

2. Objective – Interpersonal

(a) A change in the behaviour of the patient, an implied change in his attitude, an improvement in his social relationships; in work effectiveness, etc.

This is reported by others.

(b) A measurable improvement on psychologic re-testing.

(c) A change for the better in the general health and looks of the patient; a diminution in the susceptibility to minor illnesses.

3. Dynamic

A resolution of intrapsychic psychopathology as observed in the Doctor-patient relationship (transference) and as recorded in the examination of the patient's mental contents hidden from the rest of the world and hitherto from himself (the unconscious).

In my opinion, when all appearances show improvement, even *beyond* premorbid personality – which is a usual requisite of "cure" since neuroses and psychoses reach so far back in life – the severest test of change is that demonstratable in the structure and contents of phantasy, that is in sleep dreams, hypnagogic imagery, day dreams, body imagery.

Regrettably there is often a serious discrepancy between the apparent objective state and the real subjective one. The most blatant example is "cure" through flight from therapy. To wit, an attractive, intelligent girl of 21 had ceased her heterosexual interest at 15 on her father's death. She would not leave her mother's side. She replaced her father in all but the most intimate physical relationship. The inhibition of normal psychosocial drives resulted in anxiety mounting to panic if she had to leave the house alone for other purposes than to go to work and bring her wages back to her mother. The first interview foreshadowed her hidden hostility to the mother for surviving her father and a near-homosexual attachment to mother, as a defence against her own hostile impulses – her sexual emancipating drives. When she gleaned a little of this she took flight never to return. Her refer-

ring physician was very pleased and indeed astonished at my effectiveness when he reported a cessation of symptoms and an improvement in soeial relationship. I forget whether I remembered to disillusion him in me.

Repression and sublimation of factors within the complex of neurosis which immediately account for symptoms are often taken for cures; indeed they aid in temporary remissions, but a single dream analysis soon reveals the true unchanged mental state.

The obverse also happens. Frequently a release of emotions in behaviour throwing off the importunities of a sick, hyperplastic conscience leads to a horrifying report of relatives: "What have you done to my child, wife or husband? (S)he is impossible to live with; (s)he left me; (s)he swears. . . ." "To wit, a man who as a child was never free to be bad, was "loved" only through being cared for when sick. He married his "mother substitute", and drank to bury it all. Even then he could only be hostile on a verbal level. Using therapy, he figuratively beat his hated father over the head, left his employment and took up with another woman. So, he was cured and has not touched liquor since then. It used to be said, in the early days of psychoanalysis, about a person walking the streets of Vienna, "Poor chap, he has just started his treatment, in 6 months he will be divorced."

Progress since then leads to the profitable enterprise of preserving the marriage and the family by treating the more offensive and offended members of the family in succession.

No therapy is ever finished in formal Doetor-patient sessions. It eontinues as it began before the presentation of the patient, in the eontext of living with the waxing and waning of emotions reaching at times their old pathologieal intensity and their old pathologically associated ideation. Revisions on follow-up are frequently necessary.

Methods in Psychotherapy

These are based on the interview-session. The temporal phases are initiating, maintaining and ending treatment. The exchange-content in each session is usually verbal communication, predominantly unilateral: from patient to Doctor. The emotional atmosphere is one of permissiveness at the verbal level, when the patient can confess all without fear of censoring or even ethical judgment by the therapist. The emotional background is one of magic within which the past is reactivated, hidden feelings brought forth and eomfort and understanding accrues.

In the initial stage the therapist shows interest and knowledge. He exhibits a well-tried method of capturing the conscious order of events, the happenings and known feelings of a lifetime; and some of the unconscious order of events, those hitherto forgotten, half-known or never before reaching levels of awareness. He welds these, at first for himself, into a comprehensive diagnostic formulation, which he leaves open for continual modification and enlargement as he beeomes more aware of the inner life of the patient, and as he becomes wiser through experience with other patients and through his own thoughts and experience of life. Anamnestie methods are twofold; structured and unstructured. The structured method is a gentle, subtle but systematic, longitudinal and lateral investigation of the life experience of the patient; beginning with symptomatology and history of the presenting condition going through 3 generations of family history with all collaterals, recording physical, heredity, constitutional social and psyehological endowment; on to the personal history beginning in the likely motivation for the patient's birth. Then ehronologically through the first 5 years of life, the scholastic early-social era, the occupational history, sex and marital era, religious life, and then the investigation

of body and psychie self-images. Finally one turns to a systematie mental examination of the extrapsyehie apparatus: behaviour and speech. Then the intrapsyehie apparatus: affeetivity, ideation and perception.

The unstruetured method allows the patient to unfold however he wishes these life faetors, but the elinieian records them — in the orderly fashion of data-gathering. This method favours a better feeling and a more immediate abreaction through the confessional. It also favours perhaps, the earlier uneovery of what is more immediately important to the patient. Whereas the structured method tends to colleet in an orderly way in a wide variety of faets whieh the patient has overlooked or repressed, Both roads lead to Rome. The important thing is to stiek to one or the other.

The next stage is the colleetion of uneonscious order of events, the tapping of forgotten and never known facts whieh beeome data. During this deli-eate stage the Doctor-patient bond of intimacy of exehange is strengthened. The therapist explores the ideational assoeiation to pathologie feelings, examines random daily thoughts and dreams, inquires for images infiltrating before, during and after sleep (dreams) and generally stimulates the patient's imagination. He eneourages the patient to use paint material for free, nonverbal (pietorial) expressions of his inner life. Above all through frequent weekly, twiee or thriee-weekly eontact, the therapist observes the patient's minutest reaetion to the same setting and to the same person: himself. Thus the Doetor is able to penetrate through the patient's veil of mental presentation, that is through the sereen of words and eonventionality and reaeh deep meanings whieh are symbolized and felt. Thus he ean formulate the reasons for outward aetions and outwardly represented feelings. These explorations are often followed by relief of life-long by-symptoms. For instanee when the phantasy behind the fear of the dark, dating baek to ehildhood, is revealed — whether it be fear of seduetion, abduetion, murder or simply of a ghost-like figure staring from the foot of the bed — and when the patient realizes his guilt complex or whatever aeeounted for the onset and chronicity of this widespread symptom, then the fear recedes back into the darkness of the unconscious unless it has marked seeondary gains to hold it to the foreground, or unless the self-given fear expiates an unforgiveable sin.

Having gathered the data, the Doctor proceeds with interpretations and a free exchange of opinions with the patient so that a formulation ean be established between them.

In the penultimate stages the Doetor observes the patient trying to apply his new knowledge of himself and of the possibilities of new reaction to a new pattern of life. The Doctor observes and eneourages. As the Adumbratio Kabbale Christianae urges: "Quaero non pono, nihil hie determino, dietans, eoniieio, eonor, confero, tento, rogo. . . ." A free translation of whieh is: settle nothing, nor dictate nor stipulate, inquire into everything, eonfer, hypothesize, ask. . . .

In the final stage, there is a dissolution of the relationship, often with mutual emotional regret whieh is sometimes intensively felt by the patient, "Partire, c'est mourire en peu", a liberal translation of whieh is "to separate is painful". Of eourse these stages overlap and merge. While all this is what one thinks happens in psychotherapy, the following is what seems to be experieneed.

The Building Up and Dissolution of Transference

"Hodos ano kato mia kai houté" (Heraelitus) The way up and the way down are the same.

For convenience, *transference* is the term given to the special Doctor-patient relationship which is the essence of psychotherapy. It is built up through certain phases:

1. Magic and faith — These powerful emotional vestiges survive in the psyche, even in the most sophisticated intellectuals. They have been used to advantage in psychotherapy since time immemorial. It is foolish to ignore them today. The Doctor's reputation, his appearance and manner, his degrees and his professional touch, his consulting room, are the magic overtones. In fact all that is not made explicit in psychotherapy, all that remains occult is covered by a cloak of healing magic. Sometimes patients are so hypnotized by the suggestion of the curative power of the Doctor that half the emotional battle is over before they come, especially if they have to overcome the natural resistance to seeing a psychiatrist who like the wizard of old, has the power to change a person.

2. The confession — is always good for the soul. If floods of tears come, usually the result of pent-up months and years of well-deserved self pity, that is always to the good.

3. Rapport — Flattered by attention and reassured by a sympathetic attitude the patient begins to invest in the therapist his mental energy, flowing in and from his narcissistic self-centredness. If his habitual defence is not hostility, he then lays down a positive transference with the Doctor.

4. Transference—Gradually the therapist becomes as it were the recipient of the patient's neurosis. Presently the patient acts out with the Doctor, at least verbally, the major drama of the genesis, the climax and hopefully the dénouement of the neurosis.

5. Regression — In the course of this procedure, the patient returns to a childlike, dependent state. Here he finds parental attitudes which he eventually learns he had never before experienced. Fortified by a healthier, reconstituted parent-child and pseudo-sexual relationship (the pseudo refers to the sexuality in which the therapist is involved in the patient's confessed imagination), the patient accepts and gives newly freed love.

6. Adequacy — The physician's acceptance of the patient, even of the apparent irrationality, sinfulness and ugliness of the patient's body and soul, leads to a new sense of adequacy. This changes the dependency relationship to a peer one. When the Doctor ceases to play roles cast in the image (imago) significant to the patient's past genesis of neurosis, an equality relationship is established. The therapist becomes a person, a friend and rather a silent counsellor, who, like Virgil, has shown him the way, in this mundane melodrama, through the inferno and purgatory to a new kind of earthly heaven.

7. Separation — Separation was meant to punctuate man's existence and emancipate him from the womb, the umbilicus, the enfolding arms, the breast, the lap, the home, the street, the school, into the wide world alone, mated and yet alone. In the neurotic, separation is more painful than in the healthy, and more incomplete. This separation from transference has to be final after a due period of weaning, and accomplish what the others did not achieve. The patient often describes the ending of therapy "as something is dying in me". This something which is the transference is duly mourned, yet the patient also takes away with him (incorporates) part of the healthy "love" relationship he had with the Doctor, and applies it to an ever widening interpersonal sphere.

Qualities and Qualifications of a Psychotherapist

Since the Doctor himself is the potion for the patient to swallow, it is meet to

require some pharmacological purity and a knowledge of toxicology in this product.

In my opinion, he or she should be medically well qualified. The increasing huge demand for treatment has been met in part by extension of therapists to include laity with qualifications in the ancillary psychiatric disciplines. This is a vexatious quandary. Lay therapists separate psychiatry from the corpus of medicine. Rather one would that all clinicians engaged in the treatment of the sick recognize their need to gain education and controlled experience in this skill, which they have used more or less unwittingly, and are continuing to use throughout and in most of their practice. They must advance past and reverse Voltaire's wittieism, "C'est l'estomac qui fait les heureux" (It is the stomach which makes for happiness). If medicine in the future is to be re-integrated, then more than 5%, rather than less as at present, of the 5000 hours given to formal medical education should be given to psychological medicine. A basic selection and education of all medical therapists to qualify them for the explicit skill of psychotherapy would probably see to the ailing needs of humanity and do away with the haphazard spread of healers of the mind.

The equipment of the therapist may be divided into:

1. Educational
2. Personality requirements
3. Experiential

Education ineludes an awareness of the broad aspects of psychiatry: its history, psychoanalysis, neuropsychiatry, ancillary disciplines such as psychology, social work, speech therapy, etc., the techniques of interview and psychotherapy, ehild psychiatry, psychosomatic medicine, Community Mental Health, the treatment of special conditions such as alcoholism, delinquency. Knowledge of Clinical Psychiatry includes the major psychotie and neurotic syndromes, an understanding of social medicine and eomparative anthropology, industrial psychiatry, medico-legal problems, and special techniques such as child guidance, family counselling, and the use of physical adjuvants. Though this is yet a kaleidoscopic picture, an attempt to integrate it into the medical curriculum is being made in the United States, and in our University, in a modest way.

There is room for all kinds of personalities in psychotherapy – even the eccentric ones. Provided there is sensitivity to others, a balance between objectivity and subjectivity with a flair for introspection, empathy, some flexibility and an absence of the more serious emotional problems leading to such traits as pompousness, domineering, passivity, detachment and a neurotic trend to gratify the therapist's wishes on the patient, many types can be incorporated in the union of therapists. What must be avoided in the selection of therapists is pernicious psyehopathology, such as: the need for the therapist to nourish and bloat his ego on the patient, an insatiable desire to be liked by the patient, an obsessive need for perfection, a need to recreate with the patient the therapist's neurotic situations, and the projeetion of hostility. In fact all these major aspects of a *counter-transference*, from Doctor to patient, must be avoided. To achieve this, past the point of initial selection of psychotherapists, the greatest safeguard is for the therapist to know his psychologie limitations, and also for those employing him to have a fairly accurate knowledge of his toxicology. Of course the referring physician has difficulty in estimating this for he has to have some self knowledge in order to estimate how many of the adverse characteristics of the therapist are really projections of his own!

Finally it is paramount for the therapist to discard all discardable prejudiee

so as to avoid judgments especially of values in the patient. This can never be fully achieved because some of the biases hide in the anxiety of the therapist to preserve the life of his patients and to lead them to better health. But in the final analysis the therapist must even discard a certain bias or fear about the patient attempting suicide — otherwise a noxious situation may arise at a nodal point and the patient, like any other naughty child, plays on the therapist's fear in this matter. Eventually the therapist may be led to restrict the patient's activity in order to safeguard himself. The frustrated therapist may even unwittingly punish the patient with physical methods of treatment. Thus he may unwittingly allow the patient to revert to the old childhood situation of being rejected and punished with no solution to his complex. However, both rejection and punishment have their place in psychotherapy, provided the Doctor knows (or thinks he knows) what he is doing and provided he feels this is best for the patient and makes his judgment explicit. As you can see the demands and challenges on the therapist are not inconsiderable.

Experientially, the therapist must have seen many kinds of humans in many cultures. He must be aware of stereotyped relationships he himself may establish in interviews. He must have the experience of accepting many different roles and letting them be played out. He must absorb many different hurts from his patients. Perhaps the hardest hurt is that in the best therapy there is no room for great gratitude from his patient. On the contrary, he must remain anonymous socially throughout treatment, and after treatment he had best recede back into the darkness of oblivion. Consequently he must never expect and very rarely does he cover himself in some of the glory of his more fortunate medical and surgical and especially obstetric colleagues. The psychotherapists' ideal motto perhaps is "Humanum nihil a me alienum puto" (nothing human should be strange to me).

I have described, of course ineptly, a most difficult process to make explicit. Now let me give you a case, in anecdotal form, to strike in your memory at least the lighter yet serious aspects of this business. A cleric came one day and said, "You know Doctor, mental illness has no respect for the black cloth. I'm afflicted by a touch of homosexuality which is doing me no good for it has now come to the ears of my ecclesiastic authority and this is playing fair havoc in my congregation." It turned out his deviance was due in part to the importunities of a cold, unapproachable father, whom he could never impress favourably nor conquer, as all sons need to do. Moreover, he got hurt in his adolescence by his only lady love. He had turned to a Heavenly Father for a more accepting though more distant love, and in compensation for deeply felt inadequacy identified himself with Him whom he called "J. C." "Imago Dei in homine" (God's image reflected in all men). For earthly sex release, for he was still a young man, he turned to other young men who could not challenge him. But he had a curiously fixed pattern in homosexual approach. He only did this in the public baths. I agreed with him that this may be a regression to his baby bathroom scenes when he wished father would handle him. I casually remarked that it may also be a regression of his transpersonal unconscious to the days when Romans reacting to the absolute and remote power of Caesar (equal his father), and also to their guilt in persecuting early Christians, (equal his own self-esteem) debauched themselves in baths and gave themselves to sexual orgies and Bacchanalias. I also remarked that perhaps it was a *public* bath because of his rebellious protest demand-

ing exhibition to the multitudes, and also beeause exhibition in publie was a eompensation for his essentially isolated personality – (he frequented no other public plaee exeept the Chureh). He said no! to sueh abstractization of his seeular problem. Notwithstanding, in his mind he had me clearly identified with his own father. Thus the next day, with a tired glint in his eye, and defiance oozing out of him, he announeed that he again visited the baths direetly after leaving my offiee, and sedueed six men in a row. I said, with the irreverence demanded by him, that I thought there were twelve apostles, not six. He apologized for not doing well enough, and with gnashing of teeth threatened to do better. Next day, he reported a most unusual incident: at the 12th seduetion he eollapsed with the vision of Judas the Iscariot rising (no doubt from the transpersonal or eollective uneonscious) to possess his mind. From that night to when I last heard from him a year later, he had never done it again.

VASOSPASTIC DISORDERS OF THE PERIPHERAL VASCULAR SYSTEM

V. N. KYLE, 5T7

Definition

VASOSPASTIC Disorders may be defined as those eonditions in which the disturbanee in eireulation results from eonstriction in vessels, almost always indieating arteriolar spasm. Clinieally, the term arteriospastie ean be used to indieate eireulatory disorders eharaeterized by eoldness, pallor, or when there is direet visual or palpatory evidenee of deereased ealibre of vessels in the peripheral arteries.

The vasospastic disorders may be elassified into three broad eategories; Primary Raynaud's Phenomena or Raynaud's Disease, Seeondary Raynaud's Phenomena, and allied eonditions sueh as Livedo Retieularis and Aeroeyanosis.

Raynaud's Disease was first deseribed by Mauriee Raynaud in 1862. A patient exhibits Raynaud's Phenomena if he eomplains of intermittent attacks of pallor, cyanosis, or both, and numbness of the aeral parts of the extremities, as a result of exposure to eold or emotional stress.

The typieal story of Raynaud's Disease describes the dramatie or gradual onset of Raynaud's Phenomena bilaterally, in a young female on exposure to eold. Early in the disease only the fingertips are involved, the thumb often exeepted. Later the ehanges move proximally and may extend baek to include the hands.

There may be eyanosis solely or pallor solely, but more eommonly the eolour ehanges oeeur in three phases; pallor due to arteriolar spasm, eyanosis due to eapillary stagnation and rubor due to reaetive hyperemia. Paraesthesiae eommonly aeeompany the attaeks. During attaeks the fingers are eold and slight swelling of the involved fingers may oecur and persist.

In advaneed stages of Raynaud's Disease the attaeks may beeome disabling in severity and frequeney. They may oeeur on exposure to a slightly eool environment and almost any emotional stress; eonsequently even the warmer summer weather may afford little relief.

During the progression of the disease three stages may or may not be reached

depending on the virulence of the disease process. The first stage is that of intermittent spasm of digital arteries without clinical evidence of organic interference with the peripheral blood flow. The second stage is intermittent spasm of digital arteries with local nutritional changes. Here the attacks are not only more frequent, but also more prolonged, often lasting more than one hour, and consequently interfering greatly with the patient's occupation. The nutritional changes are absorption in the distal phalanges and "calcinosis cutis" characterized by a white, gritty discharge being exuded from ulcerations at pressure points. The third stage is characterized by intermittent spasm of digital arteries with sclerodactylia; a condition where excruciatingly painful non-suppurating ulcers are present. The skin of the finger tips becomes fixed to the underlying bone by the atrophic and fibrotic process. There is anhidrosis, cessation of nail growth, pitting, tapering of the fingers and paronychial infections are found in very severe cases.

Sixty to ninety per cent of Raynaud's Disease develops in females and the majority of cases occur in the first and second decades, 77% beginning before age 40. In 47% both upper and lower extremities are involved. However, the Raynaud's Phenomena always begins in the upper limbs.

A study of the family history frequently discloses migraine headaches, hypertension, and other cases of Raynaud's Disease. The attacks are sometimes aggravated at the menopause or by menstruation and may disappear during pregnancy. Characteristically the disease is associated with unusual anxiety, hyperhidrosis, tachycardia and irritable G.I. disturbances.

Due to rare opportunities for study very few significant changes have been discovered pathologically and arteriographic studies are not specific.

Raynaud originally contended that the fault was with the nervous system while Lewis advanced the theory that the changes in the digital arteries were due to a local fault. He noted that attacks could be produced easily by immersing the hands into water at 15-18° C. for 5-10 minutes. Lewis' theory however does not explain the commonly associated hyperhidrosis. Heinbecker and Bishop postulated a constitutional susceptibility of the vessel wall to circulating adrenaline. Some authors have felt that a high arsenic level in the body may be the cause while still others think that enlarged lymph nodes irritating the sympathetic chain is a possible etiological factor. At present the evidence points to both central vasomotor factors and local faults.

In order to rule out underlying obliterative disease as the etiological source of the Raynaud's Phenomena special methods of study are required. When there is some question as to whether pulsation can be felt definitely in a given artery, occlusion of the other paired artery and observations of the colour changes at the wrist or ankle are valuable in solving the point. The oscillometer or arteriogram may be needed for confirmation. When sympathectomy is contemplated vasodilatation tests should be carried out in order to prove that vasospasm is a prominent factor in producing symptoms. Such tests are most important in advanced cases in which structural changes in the skin have occurred.

The essential diagnostic criteria are the following. The Raynaud's Phenomena should have existed at least 2 years, the episodes being precipitated by cold or emotion. The vasospastic disturbance must be bilateral, and gangrene limited to minimal cutaneous grades without any underlying causative disease. The differential diagnosis should include such conditions as Buerger's

disease, arteriosclerosis obliterans, acrocyanosis, scleroderma and St. Anthony's Fire.

The treatment of Raynaud's Disease may be medical or surgical depending upon various factors, the most important of which is its severity. In the milder, non-progressive cases, the nature of the condition should be explained to the patient. She should be assured that extensive gangrene does not occur and advised to avoid the precipitating factors. Fur-lined gloves, galoshes and warm clothing should be worn in cold weather if the patient is unable to live in a warm climate. The avoidance of tobacco should be suggested.

During severe attacks oral alcohol or I.V. papaverine hydrochloride may be administered to abort the attack. These measures are rarely necessary as in the majority of cases simple warming of the body and hands is adequate to terminate an attack. Iodides, Theobromine, Papaverine and Calcium have generally been disappointing. Those episodes aggravated by the menstrual period and during the menopause may be given a trial of Estrogen therapy. Short-wave diathermy, both locally and to the regional sympathetics may produce temporary relief. Recently 2% Glyceryl Trinitrate in Lanolin has been advocated for application locally in order to produce vasodilatation.

When the Raynaud's Phenomena increase in severity with each winter one may expect that the patient eventually will have trophic changes and schlerodactylia. Under such circumstances sympathectomy is justifiable and still remains the best treatment of Raynaud's Disease. In the second and third stages of the disease where the signs and symptoms are more marked sympathectomy may be expected to result in the healing of the lesions and the relief of pain, but their subsequent recurrence may not be prevented by this procedure since vascular, but not sympathetic tone is re-established within the first 2 weeks following the operation. The sympathectomy abolishes local perspiration and therefore raises the skin temperature by preventing the loss of heat through evaporation. The vessels still remain capable of constricting to the local application of cold and to circulating adrenaline. The ideal procedure is one that will completely denervate the limb and prevent regeneration of nerve fibres. The removal of the second and third lumbar ganglia will produce almost 100% satisfactory results in the lower extremity. In the upper limb the stellate, second dorsal and if possible the intermediate cervical ganglia should be extirpated. Here 10-15% receive complete and permanent relief; 50% good, but not complete relief, and the remainder, transient or no relief. Pre-ganglionic ramisection, in order to avoid a postulated hypersensitivity of the blood vessels following ganglionectomy has not improved results. Complications of this surgery may be Horner's Syndrome, nasal congestion, perilesionary sweating, hyperhidrosis of the trunk or loss of venous tone. The late result from sympathectomy in Raynaud's Disease will depend upon the completeness of the operation, the stage of the disease in which the operation was performed and the extent and speed of regeneration of the sympathetic nerves or on the individual's hypersensitivity to vasoconstricting substances in the blood.

It is worth mentioning that in his original classification Raynaud included some of these disorders by mistake in his description of Raynaud's Disease. There are 5 major divisions of this classification, each with several subdivisions.

The first is one in which Raynaud's Phenomena develops following trauma. This trauma may be related to the patient's occupation such as occurs in

pneumatic drillers and less frequently in pianists and typists or it may be the result of injury or surgery. Sudek's atrophy and acute segmentary arteriospasm fall into this category.

The second major division includes Neurogenic lesions more specifically the cervical rib, scalenus anticus syndromes and diseases of the nervous system, particularly lesions in the midbrain and internal capsule.

Occlusive arterial diseases such as Arteriosclerosis obliterans, Thromboangiitis obliterans, and embolism account for the third major division and intoxication with heavy metals or ergot the fourth division.

The fifth major division is entitled miscellaneous and includes such entities as scleroderma, lupus erythematosus, polycythemia, hypoglycaemia, hypothyroidism, cold hemagglutination and cryoglobulinaemia.

In summary, the vasospastic disorders are of varied etiology and consequently the patient should be examined with this thought in mind. A careful history and physical examination coupled with an intelligent investigation will considerably narrow the range of etiological factors.

THE CAUSES OF ALCOHOL ADDICTION

J. M. HARVEY, 5T7

DRUG addiction is a way of life involving the repeated use of toxic doses of a compound because of some effect that the drug produces. We will attempt to show why a person becomes addicted. There are two forms of addiction — primary and secondary. The secondary type is that form of addiction that is acquired by accident. Thus the person is introduced to a drug because its use is a social custom or he is addicted during the course of treatment of a medical condition. These persons are relatively easy to free from their addiction.

The primary type of addiction is the addiction that occurs in a person because he has some inner need that is satisfied by the drug. This need may be considered the predisposing cause of the addiction, while the situation that introduces the person to the drug, thus becomes the precipitating cause.

We may now quite justifiably ask — What is this predisposing cause? We shall limit our examples to the alcohol addict, though there are many drugs from which to choose.

Little in the way of psychological and psychiatric evaluation has been done on this large and unfortunate portion of the population. From the investigation of the little literature that is available, all authors seemed to agree that the basic fault is in the personality. However the explanations naturally vary with the author's interpretation of the test results. The basic premise is, that the alcoholic is an inadequate personality, and the use of alcohol is an endeavour, by this personality, to overcome his inadequacy. Some of the theories are as follows:

Georgio Lolli claims that alcohol and alcoholism are problems of the love-power-justice complex that is in all persons. Thus no understanding of the problems of the alcoholic, is possible until these basic problems of the love-power-justice complex are understood. It is my impression that these complexes

are not well understood at this time, so that Lolli's theory at the present time is of little practical use to us.

Another theory that has been advanced is that the alcoholic is a person who lives under the tyranny of his past, that is of his very early childhood, when he received all of his needs at his mother's breast. However, what is normal in the infant is perverse in the adult, and he turns to alcohol as the outcome of his inhibitions or his distortion of his hunger-linked emotions. This is because alcohol is capable, in the aleoholie, of supplying all his needs both physical, in the way of calories, and psychological, in the way of feelings of warmth with the blotting out of that which is undesirable.

Chandler Washburne in his theory states that society is built up of roles and everyone has his role. Thus a person acts as he feels that society demands that he act. However the alcoholic cannot act as he believes society expects that he should. Consequently he turns to alcohol with the expeeted role that goes with the use of this in society.

One last theory is based on the concept of time and all that it signifies in the relation between the individual and his fellows. In Western society today there is great stress laid upon individualism, the future, and the fluidity of the group-personal relationships. This would appear to be opposed to all the basically gregarious feelings of man. The solution to this problem is fraught with tension as basically man seems to be a gregarious, future-fearing and death-fearing animal. Alcohol is a good soporific for the person who has any problems of adjustment to this situation. Here alcohol is an excellent escape from all three — it blots out the past failures, and the future fears, and creates a measure of companionship that we all seem to need.

Throughout all the theories is the theme that whatever the cause, from a psychiatric point of view, the end result is the production of stress. As all persons in our society, that are aware of their surroundings, are subjected to the same outward stresses, within limits, the problem of the addict resolves itself, to my mind, into the inability to tolerate this stress, or else the defect in the personality makes the normal stresses of living seem so much more unbearable. Thus, in comparison to the non-addict, the addict has a low stress tolerance.

Everyone has stress reducing mechanisms. Without them we would probably all crack under the strain, or else develop ulcers. It would appear that the aleoholic does not possess the normal mechanisms or else they are deficient to such an extent that he cannot resolve these everyday stresses. Somewhere along life's path, the addict is introduced to chemicals that to him are pleasurable — that is in all probability they are tension-reducers, or at least to the potential addict they appear as such.

Having dealt with the predisposing causes in a very superficial way I shall now attempt to outline some of the precipitating causes. These situations as has been previously mentioned are the stress situations that arise in everyday life.

Because man is a gregarious creature by nature the main precipitating causes will be directly related to interpersonal relationships. These may be dealt with in the order in which the developing human comes into contact with other humans. Thus they will inevitably arise in the home. Here the sibling rivalries and the unresolved Oedipus complex will be a source of trouble. Next the school with its many problems will be a source of aggravation. When the individual is thrust out into the business world, he will be confronted with ever increasing stress situations. Social situations will be precipitating factors to some other individuals. Finally the

problems of the future, and the inevitable exit from this world, and what will happen after this, may be another source of anguish to the human as he grows older.

As the appearance of addiction will be modified by the time that the precipitating factors arise, whether these situations at any time will give rise to an addiction will depend upon the age of the person at the time they arise. Thus if sibling rivalry is very distressing to an individual before he has attained an age where he is capable of procuring sufficient alcohol to develop an addiction, addiction is not possible. However the unhealthy groundwork is there for future troubles.

The other great source of precipitating factors is the stress laid by our present day culture, upon success. Everyone will have his own ideas of what to him is success and conversely he will have a never ending fear of what to him is failure. These ideas arise as the individual develops and the basic concepts are present in the individual long before the child has any realization of what they will mean to him in the future. These ideas are the results of family hopes and desires and of triumphs and defeats. These ideas, that are instilled into the child from the very beginning, in most cases take nothing into account as far as the child's capabilities and aptitudes are concerned. They are usually related to the parents' ideas of what their child's capabilities, aptitudes and desires should be. Thus in many cases the child has to try to reconcile his own and his family's ideas when he reaches maturity. This is very easily appreciated in the exaggerated case of the sueeessful parents with a defective child. The parents expect that their child will graduate from university and become a suecessful business tycoon. Of course this is not a stressful situation unless the child grasps the ideas of success that have been instilled into him and is also capable of appreciating that, for some reason over which he has no control, he cannot hope to reach these pinnacles that are set for him.

Finally I should like to briefly outline my ideas as to the programme of treatment that will have to be undertaken in order to help these primary addicts. It goes without saying that the first part of the treatment will involve getting the addict off his drugs, and trying to relieve and reverse the damage that has been done to the organism by the drug. However, as far as I am concerned, it will not have any success if the person is not treated for the basic problem – namely the "Inadequaey" whatever this may be. Any attempt at treatment should not be undertaken unless some measure of cooperation can be obtained from the addict to be treated.

The first part of this problem is to a large extent Medical. The second and the most important part of the problem to my mind, is still in many respects unresolved. Here the treatment involves introducing into the addict, by the many deviees of psychiatry, what amounts to a new personality and outlook. To reach this objective, first of all, requires far more capital than is available at the present time. (Capital here refers to the boardest sense of the term and includes personnel and clinic facilities as well as the necessary finances and research to back up the treatment programme.) To gain this, public education and sympathy are required. At the same time some of the other objectives of the proposed treatment will be attained. Facilities for the psychological and psychiatric evaluation of the addict must be available, as the treatment of the basic personality disorder cannot be undertaken if the disorder is not known. As with most psychiatric problems the mainstay of treatment will be the sympathetic understanding of the per-

son; and the use of the rapport gained by this, to help the addict gain insight into his problem. Another part of the scheme is the resocialization of the addict, with the acceptance of the new personality by the former family and friends. This ideal, as with many other desired situations in Medicine, cannot be hoped to be achieved in all cases.

In summary, it is my contention that the etiology of addiction is a basic personality defect so that the person has poor tolerance to stress. Thus he turns to drugs for the resolution of his problems. I have tried briefly to outline a few of the theories that are currently held as to the source of the personality disorder. In the way of treatment, attention must be paid to more than the immediate problems of associated disease from the use of drugs. The short-term treatment of only weaning the addict off of his drug without attacking this basic personality disorder will yield poor results to say the least. The attack upon this will involve the use of psychiatric and social agencies as well as the wholehearted support of a well informed and educated public.

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PHYSICAL DISEASES DUE TO ALCOHOL ADDICTION

J. A. L. GORDON, 5T7

ONE aspect of addiction concerns the physical diseases resulting from prolonged use of harmful quantities of a drug. This paper is confined to the physical diseases resulting from alcohol addiction.

I have divided these conditions into the following groups:—

A. *Diseases resulting from the Depressant Effect of Alcohol on the CNS.*

1. Acute inebriation
2. Alcholic Tremulousness
3. Alcoholic Hallucinosis
4. Delirium Tremens
5. Alcoholic Convulsions

B. *Nutritional Diseases Secondary to Alcoholism*

1. Wernicke's Disease
2. Korsakoff's Psychosis
3. Alcoholic Polyneuropathy
4. Alcoholic Pellagra
5. Fatty liver and Cirrhosis

C. Diseases due Directly to Alcohol Ingestion

1. Alcoholic Gastritis
2. Alcoholic Pancreatitis

Acute Inebriation is the earliest clinical picture resulting from the depressant effect of alcohol on the Central Nervous System. The clinical picture presented by such a person is familiar to all and although the variation between individuals is considerable, recognition is usually easy. Some individuals become pathologically intoxicated and can recall nothing of their behaviour during a drinking bout; some become disturbed and combative while others become stuporous and comatose. The frequency of this condition can be appreciated

when it is realized that 59% of patients admitted to Boston City Hospital in coma were suffering from acute alcohol intoxication.

Alcoholic Tremulousness is the commonest cause of alcoholic admission to hospital and refers to the state commonly called the 'shakes' or 'jitters'. The alcoholic usually experiences these tremors in the morning, after the period of relative abstinence during the night. They are associated with anorexia, nausea and vomiting and may or may not be associated with any of the other conditions in this group. At first they are relieved by alcohol only to return with increasing persistence and severity. The tremor is widely fluctuant being mildest at rest, gross and irregular during activity and extremely marked during periods of agitation. This is the so-called 'Stage 1 Withdrawal Syndrome' and will disappear gradually and completely over 1 to 2 weeks of abstinence.

Alcoholic Hallucinosis is the occurrence of symptoms of disordered sense perception seen in about one-quarter of all tremulous patients. Because of the very great difficulty experienced by the patient in separating these symptoms from real experience, the occurrence of hallucinations is often not volunteered by the patient unless direct questioning is given by the examiner. Visual hallucinations are five times as common as auditory or mixed types and they are more severe at night resulting in nightmarish episodes and seriously disturbed sleep. In all but the most severe forms, the hallucinations are intermittent in nature and seldom last longer than 3 days.

Delirium tremens is a more serious but less common syndrome due to the depressant effect of alcohol. It may be seen either in the steady excessive drinker of many years duration who undergoes abstinence for any reason, or in the so-called "spree drinker" who at the end of his bout of heavy drinking suffers from hallucinations, tremors or seizures for several days before becoming delirious. The clinical picture presented by a patient with delirium tremens is a combination of several of the following features; excessive motor activity as revealed by tremulousness, restlessness, and very marked talkativeness; increased autonomic activity as revealed by rapid pulse, sweating and fever; disorders of sensory perception as revealed by illusions and hallucinations; disorders of mood as revealed by acute agitation and distress and excitement; delusions and finally disturbances of attention and very marked confusion. The clinical state, which is a very colorful and dramatic one, lasts for several days to two weeks and gradually abates. In about 10% of cases, relapses and recurrences of delirium tremens occur and the recovery period is quite prolonged. The majority of patients suffer only one attack and 80% of these single episodes are over in 3 days. Fatal outcome is reported as being between 5 and 15% usually due to other illnesses such as pneumonia or to injuries. In the remainder, the cause of death is not understood even at autopsy. Acute Auditory Hallucinosis is a variant of delirium tremens seen only in chronic alcoholics. It is also called Kraeplin's Hallucinatory Insanity of Drunkards or Wernicke's Acute Alcoholic Hallucinosis. The central feature here is auditory hallucinations in which the patient hears threatening or maligning voices but otherwise is well-orientated and lacks the typical psychomotor overactivity of delirium tremens.

The relationship of alcoholism to epilepsy and convulsions has been appreciated for a long time. The closest relationship between convulsions and alcohol is seen in those patients who develop seizures for the first time only after years of excessive drinking. These true types of "rum-fits" have their onset in adult life and must be placed in a different category than so-called ideo-

pathic epilepsy. These seizures are related to abstinence from alcohol after a period of excessive ingestion and are most often associated with delirium tremens. In one series of 101 patients with delirium tremens, 30 suffered from convulsions. The seizures are always grand mal in type and although they may occur singly, they more often occur in short bursts of 2 to 6 seizures. Whether alcohol simply precipitates latent epilepsy or is able by itself to provoke convulsions in persons having no epileptic disposition is the major question which has not as yet been answered. No pathological lesions have been found in persons dying of alcoholic epilepsy and EEG records taken between drinking bouts appear quite normal. In a series of patients suffering from ideopathic epilepsy, half of those who used alcohol excessively found that it resulted in more frequent and severe seizures than before.

The etiology of the above conditions remains unsettled because, although alcoholism is the underlying factor, the mode of action is obscure. The older theories which sought to explain the syndromes on a toxic or nutritional basis have largely been replaced chiefly because so many of the symptoms can be relieved by alcohol itself and because patients on normal diets still develop the above clinical pictures. The most reasonable approach seems to be that the above conditions are reactions of withdrawal or abstinence from alcohol. This approach can be explained as follows: Following prolonged excessive ingestion of alcohol, there is an alteration in the normal homeostatic mechanisms of the human body so that near-normal functioning is possible in the presence of grossly elevated blood alcohol levels. As long as these blood alcohol levels are kept elevated, the person can function in a reasonable manner. Following withdrawal from alcohol, blood levels fall and the internal environment of the body is altered. By some means as yet unsettled, this alteration in the internal environment produces gross alteration in body function. The evidence in support of this concept is that all of the above clinical pictures can be relieved by restoring the blood alcohol to the same level reached during periods of excessive ingestion. The biochemical and neurophysiological mechanisms responsible for the production of the above symptom complexes are not as yet understood. Because of the noted resemblance between the stress syndrome and delirium tremens, many efforts have been made to prove that the syndromes are due to deficiencies of endocrines particularly of the pituitary-adrenal cortex axis. Attempts have been made to avert the onset of withdrawal syndromes in expected cases and to treat established cases of the syndrome by using adrenal cortical extracts and ACTH. Although many encouraging reports have been published, I think it is safe to say that as yet there is no conclusive evidence that the use of these hormones has had much effect on the treatment of these syndromes. At the present time, the standard therapy remains based on adequate sedation, fluids and general supportive measures including vitamins, calorie rich, protein rich, and carbohydrate rich diet. Many clinics make use of intravenous insulin and glucose injections to produce drowsiness and sleep in the actutely agitated alcoholic in severe withdrawal reaction. Paraldehyde is another very useful sedative for patients in this group and the introduction of the tranquilizing drugs has provided the clinician with a host of new preparations. Insufficient data has been published to date to compare the various preparations in the field and at the present time it remains largely a question of personal preference. Sparine is probably the most effective drug in this group.

In 1881, Carl Wernicke described an illness of sudden onset characterised by mental disturbances, paralysis of eye movements and an ataxic gait. The crux of the clinical syndrome known as Wernicke's disease is the ocular abnormality most commonly revealed as a horizontal nystagmus on lateral gaze. The second consistent sign is mental disturbance which consists primarily of memory loss especially for recent events and often associated with disorientation as to time and place, confusion and lack of consistency in speech and thought. The third prominent sign in this syndrome is ataxia of gait which varies in severity from a complete inability to stand without support to milder cases where the patient is able to walk with short uncertain steps in a wide-based reeling type of gait.

Pathologically, the lesions are found in the paraventricular regions of the thalamus, hypothalamus, around the aqueduct of the midbrain and on into the floor of the fourth ventricle. Microscopically, necrosis of both nerve cells and nerve fibres is seen. The specific nutritional factor concerned in most if not all of the symptomatology of Wernicke's disease is thiamine deficiency. With thiamine alone in the diet, the ocular signs improve over a matter of hours and the ataxia gradually diminishes although some degree of permanent deficit is not unusual. The mental state also improves but memory deficit and confabulation once firmly established, improve only a little over several months or years.

In 1887, Korsakoff, a Russian psychiatrist described a characteristic mental disorder seen in the malnourished and particularly in alcoholics, which he called 'psychosis polyneuritica'. The most prominent feature of this condition is very marked memory loss experienced by these patients for both recent and remote events. The patient has great difficulty or may find it impossible to commit to memory even the simplest of facts and if he is able to learn them, he finds that they have eluded him in a matter of minutes. This memory loss may be the only demonstrable mental disturbance in these patients but confusion and confabulation are frequent findings. Associated delirium tremens is quite common and nutritional polyneuropathy was reported in 60% of cases of Korsakoff's in one series. Wernicke's disease bears such a common relationship to this syndrome that some authorities feel that Korsakoff's psychosis is the mental component of the same process that causes Wernicke's disease. Treatment consists of an adequate diet with all the essential foodstuffs and particularly the B complex vitamins, of which thiamine is felt to be the most important. The prognosis is variable and mild cases will recover completely. More severe cases make slow progressive recovery over a period of years but mental deficits often remain and many will be sent to psychiatric or chronic disease hospitals.

The third large group of nutritional disorders associated with alcoholism is peripheral neuropathy. The specific nutritional factor involved here is probably thiamine because although it has not been possible to produce typical alcoholic polyneuropathy in birds and human volunteers by a thiamine deficient diet, persons with the disease do recover when thiamine alone is added to their diets in sufficient amounts. Polyneuropathy rarely occurs in the absence of other signs of nutritional deficiency such as Wernicke's or Korsakoff's syndrome and liver disease. The clinical picture is a variable one with complaints of progressive weakness, paraesthesiae, pain and sensory loss. Very often the condition is an incidental finding during routine examination of an alcoholic being treated for other aspects of the disease. The clinical findings are those of varying degrees of motor, sensory and reflex

loss with symmetrical distribution of the signs, more prominent in distal portions of limbs and often confined to the legs. Treatment consists of adequate diet with Vitamine B supplements and appropriate physiotherapy to precent the development of contractures. Recovery is slow and may take many months. Residual deficit is seen in the most severe cases.

There are no essential differences in the clinical features of pellagra in alcoholics and non-alcoholics. The treatment is niacin.

The close association between portal cirrhosis and alcoholism has been known for a long time and the clinical picture of alcoholic cirrhosis is identical with that of the other forms of portal cirrhosis. Approximately 70% of all patients with portal cirrhosis give a history of chronic alcoholism but at a maximum only 30% of all chronic alcoholics develop cirrhosis. In a study of 430 consecutive patients admitted to the Brookside Sanitorium with alcoholism, 47% were found to have some form of liver disease. The primary injury is probably chronic nutritional deficiency combined with possible toxic effects of alcohol. The actual nutritional deficiencies are felt to be of the lipotropic factors — methionine and choline. It has been found that the liver of alcoholics can be protected against fatty degeneration and cirrhosis by a dietary intake of .3% choline chloride or 25% protein intake in the diet. Treatment of alcoholic cirrhosis consists in adequate dietary intakes of calories, proteins and vitamins.

The symptoms of gastritis are common in alcoholism and include abdominal distension, epigastric distress, belching and a typical ulcer-like symptoms. These are temporary in nature only and can be relieved by aluminum hydroxide gel.

Alcohol is an important factor in the production of pancreatitis. The exact role of alcohol in producing pancreatic necrosis is not clear, although Rich has theorized that there is stimulation of pancreatic secretion and rupture of the acini with liberation of pancreatic enzymes following ingestion of alcohol. Many emergency abdominal operations in alcoholics for perforated peptic ulcer could be avoided by the routine use of serum amylase determinations in all alcoholics with acute upper abdominal pain.

The above aspects of alcohol addiction are of considerable interest and importance as it is because of these complaints that the majority of alcoholics will seek medical help. Also it is against these aspects of alcohol addiction that the majority of medical therapy is directed.

NEWS AND NOTES

A most significant and generous contribution for research in the diseases of the eye has been given to the University of Toronto by Mr. Herbert G. Stapells, Q.C., Toronto corporation lawyer.

His donation of $25,000 will be used for clinical research by members of the staff of the Department of Ophthalmology in the University's teaching hospitals, and will also be used to defray expenses of staff members for short periods of study in other research centres.

The Department has received large support from government sources for its eye research program, but few private individuals have supported clinical eye research to such an extent.

The following awards have been made:

The Joseph Aziz Bursary

H. J. Donsky (I Med. Yr.)

Medical Alumni Association Bursaries

J. S. Burger	(II Med. Yr.)
W. P. Butt	"
P. Greenhow	"
R. G. Guest	"
M. A. Burak	(III Med. Yr.)
C. P. Marks	"
G. M. Novotny	"
P. E. Perry	"
W. B. Wernick	"
I. Yablon	"
N. L. Kramolc	(IV Med. Yr.)
N. E. Stratas	"
S. B. Venis	"

The Alpha Omega Alpha Honour Medical Society is pleased to announce members elected in September, 1956. Those elected from Fourth year include Messrs. M. Baida, G. F. Coulter, D. Glick, J. A. L. Gordon, V. N. Kyle, L. W. Organ, M. Paul, S. Rabinovich, P. D. Steinhauer, S. B. Venis, and Miss M. E. Robertson. Those elected from the Third Medical Year include Messrs. G. D. Blenkarn, S. Sidlofsky, G. I. Urbach, and Miss M. G. Norman.

ADDRESSES OF THE GRADUATING CLASS 1957

Baida, M.	Toronto Western Hospital, Toronto
Bard, M. G. B.	Conemaugh Valley Memorial Hospital, Johnstown, Pa.
Barnes, C. W.	Hamilton General Hospital, Hamilton, Ontario
Bate, J. T.	Toronto Western Hospital, Toronto
Beesly, Miss M. G.	Toronto General Hospital, Toronto
Berger, M. R.	Regina General Hospital, Regina, Sask.
Bingham, J. M.	Montreal General Hospital, Montreal, Quebec
Bobeehko, W. P.	Toronto General Hospital, Toronto
Bolland, P. G.	St. Joseph Hospital, Flint, Michigan
Borseh, R. N.	St. Michael's Hospital, Toronto
Bull, A. L.	Montreal General Hospital, Montreal, Quebec
Burke, W. D. J.	St. Joseph's Hospital, Toronto
Cameron, H. O.	Toronto General Hospital, Toronto
Campbell, J. D.	Toronto East General Hospital, Toronto
Cartwright, D. B. M.	Toronto Western Hospital, Toronto
Chevalier, Miss L. M.	Montreal General Hospital, Montreal, Quebec
Chizen, J. H.	University of Alberta Hospital, Edmonton, Alta.
Chlebus, A.	Toronto General Hospital, Toronto
Christensen, K. H.	St. Joseph's Hospital, Toronto
Christie, R. J.	Toronto Western Hospital, Toronto
Cohen, D. F.	Doctors' Hospital, Seattle, Washington
Connell, G. F.	Hamilton General Hospital, Hamilton, Ontario
Coppolino, A. G.	St. Michael's Hospital, Toronto
Coulas, L. G.	St. Joseph's Hospital, Toronto
Coulter, G. F.	Toronto Western Hospital, Toronto
Cowan, Miss M. D.	St. Michael's Hospital, Toronto
Crapper, D. R.	Toronto General Hospital, Toronto
Creighton, R. J.	St. Joseph Hospital, Flint, Michigan
Das, Miss E.	Willowdale, Ontario, 20 Doris Avenue
Day, R. A.	Toronto Western Hospital, Toronto
Deadman, J. C.	Toronto Western Hospital, Toronto
Duff, J. H.	Toronto Western Hospital, Toronto
Dwyer, D. E.	Toronto General Hospital, Toronto

Edwards, R. B.	Toronto General Hospital, Toronto
Effer, S.	St. Joseph's Hospital, Toronto
Enright, T. J.	St. Michael's Hospital, Toronto
Farber, E. P.	Toronto General Hospital, Toronto
Feld, R.	New Mount Sinai Hospital, Toronto
Fenyvessy, J. Z.	St. Joseph's Hospital, Toronto
Fielden, R. H. N.	Toronto General Hospital, Toronto
Fine, L.	King's County Hospital, Brooklyn, N.Y.
Fine, S.	Peterborough, Ontario, 531 King Street
Foote, R. J.	St. Michael's Hospital, Toronto
Giblon, B. I.	New Mount Sinai Hospital, Toronto
Glass, D. E.	Cedars of Lebanon Hospital, Los Angeles, Calif.
Gliek, D.	New Mount Sinai Hospital, Toronto
Gollish, I.	Toronto East General Hospital, Toronto
Gordon, J. A. L.	Toronto Western Hospital, Toronto
Green, R. P.	Merey Hospital, Pittsburgh, Pa.
Grogan, D. R.	Toronto General Hospital, Toronto
Grossberg, N. M.	New Mount Sinai Hospital, Toronto
Gryfe, C. I.	New Mount Sinai Hospital, Toronto
Hamilton, J. W.	University of Alberta Hospital, Edmonton, Alta.
Harvey, J. M.	Toronto General Hospital, Toronto
Heetor, R. I.	Toronto General Hospital, Toronto
Hoaken, P. C. S.	Memorial Hospital, Danville, Va.
Hooper, R. L.	Toronto General Hospital, Toronto
Huffman, Miss J. L.	St. Michael's Hospital, Toronto
Husehilt, N. P.	St. Joseph Merey Hospital, Ann Arbor, Miehigan
Irwin, P.	Toronto General Hospital, Toronto
Johnson, D. H.	Toronto Western Hospital, Toronto
Kapsos, J. E. J.	St. Miehael's Hospital, Toronto
Kasten, S. L.	Detroit Receiving Hospital, Detroit, Miehigan
Kay, M. S.	New Mount Sinai Hospital, Toronto
Keltz, M.	New Mount Sinai Hospital, Toronto
Kinash, B.	St. Miehael's Hospital, Toronto
King, H. F.	Toronto Western Hospital, Toronto
Kingstone, S.	Toronto East General Hospital, Toronto
Kirsh, J.	New Mount Sinai Hospital, Toronto
Kosar, S. J.	Toronto Western Hospital, Toronto
Kramole, N. L.	Toronto East General Hospital, Toronto
Kyle, Mrs. M. J.	Toronto East General Hospital, Toronto
Kyle, V. N.	Toronto General Hospital, Toronto
Lax, L. C.	Sunnybrook Hospital, Clinieal Investigation, Toronto
Lee, R. B.	Toronto General Hospital, Toronto
Lewis, Miss B. A.	St. Michael's Hospital, Toronto
Liedtke, Miss D. F.	St. Miehael's Hospital, Toronto
Loggie, Mrs. M. E. J.	St. John's General Hospital, St. John's, Nfld.
Loney, E. M.	Toronto East General Hospital, Toronto
Lorimer, W. R.	St. Joseph's Hospital, Toronto
Lowden, J. A.	Toronto Western Hospital, Toronto
MeCuaig, K. O.	Metropolitan General Hospital, Windsor, Ontario
MaeKenzie, T. C. M.	Toronto Western Hospital, Toronto
MeNaught, T. R.	Vancouver General Hospital, Vaneouver, B.C.
MaeNiel, H. C.	University of Alberta Hospital, Edmonton, Alta.
Manuel, F. R.	Charity Hospital of Louisiana, New Orleans, La.
Martin, R. F.	Toronto Western Hospital, Toronto

Matsusaki, H.	Hamilton General Hospital, Hamilton, Ontario
Moran, D. J. L.	Toronto General Hospital, Toronto
Moran, E. J.	St. Michael's Hospital, Toronto
Morphet, J. A. M.	Hamilton General Hospital, Hamilton, Ontario
Mudie, L. H.	Toronto Western Hospital, Toronto
Mull, J. D.	Victoria Hospital, London, Ontario
Nabeta, Miss S. S.	St. Michael's Hospital, Toronto
Naprawa, T. S.	St. Michael's Hospital, Toronto
Oliver, Miss E. A.	Toronto General Hospital, Toronto
Organ, L. W.	Toronto General Hospital, Toronto
Paul, M. M.	New Mount Sinai Hospital, Toronto
Peacock, Miss D. A.	Toronto East General Hospital, Toronto
Petrie, D. J. R.	Toronto Western Hospital, Toronto
Pickett, C. H.	St. Joseph's Hospital, Toronto
Prime, F. M.	Calgary General Hospital, Calgary, Alberta
Rabinovich, S.	Toronto General Hospital, Toronto
Robertson, G. R.	Vancouver General Hospital, Vancouver, B.C.
Robertson, J. D.	Toronto Western Hospital, Toronto
Robertson, Miss M. E.	Toronto General Hospital, Toronto
Roe, R. D.	St. Michael's Hospital, Toronto
Roebuck, M. J.	New Mount Sinai Hospital, Toronto
Romano, W. L.	Metropolitan General Hospital, Windsor, Ontario
Rotstein, J.	University of Chicago Clinics, Chicago, Illinois
Seime, C.	St. Michael's Hospital, Toronto
Shaul, C. H.	New Mount Sinai Hospital, Toronto
Shier, D. J.	Toronto Western Hospital, Toronto
Sochaniwskyj, W.	St. Joseph's Hospital, Toronto
Spragge, J. W.	St. Michael's Hospital, Toronto
Stancer, H. C.	King's County Hospital, Brooklyn, N.Y.
Steinhauer, P. D.	Toronto Western Hospital, Toronto
Steedman, J. A.	University of Alberta Hospital, Edmonton, Alta.
Stipec, J.	Vancouver General Hospital, Vancouver, B.C.
Stratas, N. E.	Memorial Hospital, Danville, Va.
Taylor, H. M.	Toronto East General Hospital, Toronto
Tennen, A. B.	New Mount Sinai Hospital, Toronto
Tile, M.	Toronto East General Hospital, Toronto
Tucker, A. G.	Hamilton General Hospital, Hamilton, Ontario
Turliuk, N.	Hamilton General Hospital, Hamilton, Ontario
Turner, Miss K.	Toronto East General Hospital, Toronto
Tuttle, Miss N. L.	St. Luke's Hospital, Kansas City, Mo.
Tytaneck, W. N.	Mercy Hospital, Buffalo, N.Y.
Venis, S. B.	New Mount Sinai Hospital, Toronto
Wallace, Miss S. J.	Toronto General Hospital, Toronto
Warme, G. E.	Vancouver General Hospital, Vancouver, B.C.
Wheler, R. J.	Vancouver General Hospital, Vancouver, B.C.
White, J. F.	Toronto East General Hospital, Toronto
Whiteside, J. H.	Toronto Western Hospital, Toronto
Whittaker, A. T.	St. Joseph Hospital, Flint, Michigan
Williams, D. R.	St. Joseph's Hospital, Toronto
Young, P. W.	University of Alberta Hospital, Edmonton, Alta.
Young, W. E.	St. Michael's Hospital, Toronto
Zucker, B. B.	Toronto Western Hospital, Toronto

ERRATA IN MARCH, 1957 ISSUE

Psychotherapy — Kinds of Therapy

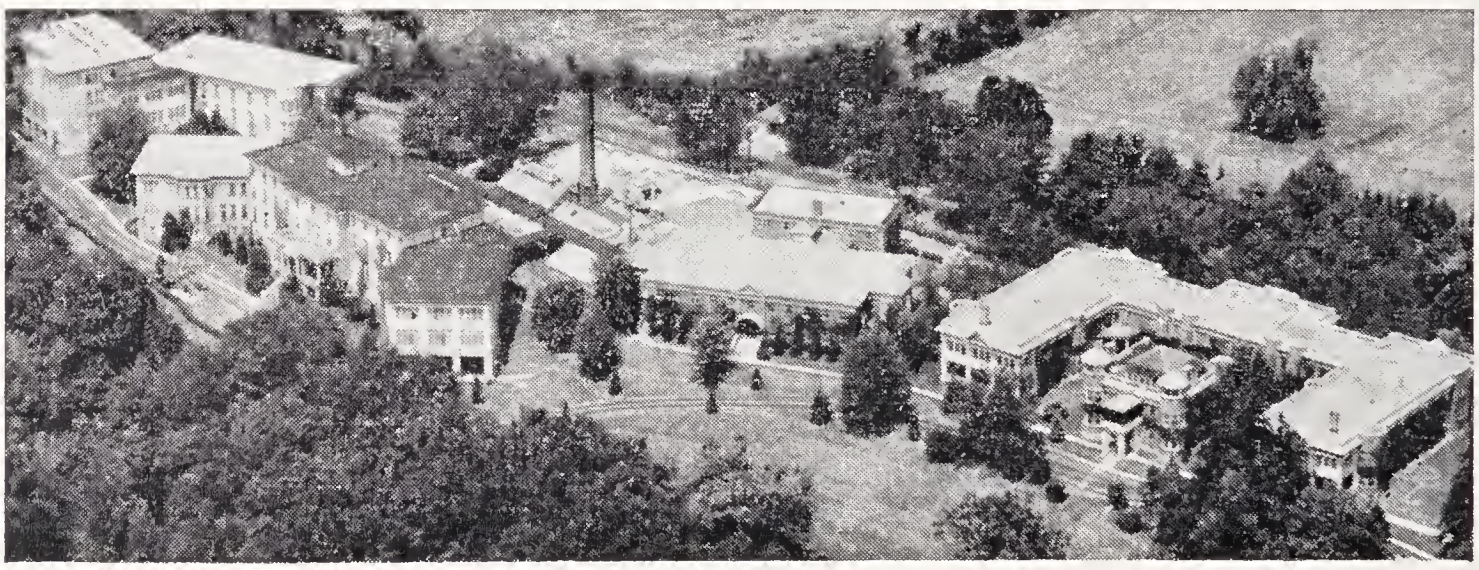
P. 156, Column I
l. 8 Spelling, "hypnotics"
After Sect. 4. insert new Sect. 5. to read:
"5. Continuous narcosis—for days and weeks of total rest and sleep."
Original Sect. 5, 6, 7, become Sect. 6, 7, 8, respectively
l. 27-30 Correct to read
"7. Insulin"
(a) "Modified" — for sedation, weight increase and "subcoma". Useful in certain neuroses.

P. 156, Collumn II
l. 25 "*faute de mieux*"

P. 157, Column I
l. 27-28 Corrected to read:
"(d) The time be brief, i.e., 3 months or less, or given to long term methods."

P. 157, Column II
l. 11-12 Delete: "and the related complaint"

P. 158, Column II
l. 19 Spelling, "acculturation . . ."



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References: 1. Dinkel, R. M.: Eugenics Quart. 3:22 (Mar.) 1956. 2. Grove, R. D.: Am. J. Pub. Health *46*:592 (May) 1956. 3. Novak, E., and Novak, E. R.: Textbook of Gynecology, Baltimore, The Williams & Wilkins Company, 1956. 4. Tietze, C.: Proc. 3rd Internat. Conf. Planned Parenthood, 1953.

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Children 40 to 60 lb. (2-5 years) 3 teaspoonfuls or 6 tablets
Children over 60 lb. and adults
4 teaspoonfuls or 8 tablets (maximum dose)

These quantities should be administered in a single dose before or after breakfast for 6 consecutive days.

Whatever procedure is adopted, cure must be established by determining the absence of ova by means of the anal swab.

ROUNDWORMS: One 5 to 7-day course of treatment is usually sufficient.

CAUTION: With overdosage the following reactions may occur: nausea, giddiness, lack of co-ordination, flashes on closing the eyes, inability to focus vision and a sense of detachment. These untoward effects are temporary and disappear when medication is discontinued.

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